Statement of Mary Helen Tieken, R.N., B.S.N.
Owner/Administrator, Nurses In Touch, Inc.
President-Elect, Texas Association for Home Care

ON

The Impact of CMS Regulations and Programs on Small Health Care Providers

Before the House Committee on Small Business
Subcommittee on Regulations, Health Care and Trade

May 14, 2008

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Chairman Gonzalez, Mr. Westmoreland, distinguished Members of the Committee, thank you for inviting me here today to discuss the impact of CMS regulations and programs on small health care providers, particularly small home and hospice care providers.

My name is Mary Helen Tieken. I am a registered nurse and the owner and administrator of Nurses In Touch, Inc., a Medicare-certified home health and hospice provider located in Floresville, Texas. I have operated this company since 1990, serve 280 patients over 16 counties, and have 185 employees. I am also here today as the President-Elect of the Texas Association for Home Care, a non-profit trade association that represents more than 1,200 licensed home and community support services agencies that provide home health, hospice and personal assistance services in Texas.

I come before you today to share the impact of regulations and policies issued by the Centers for Medicare and Medicaid Services (CMS) have on small providers. Home health agencies and hospices face numerous challenges in delivering quality services to Medicare beneficiaries. We frequently must adhere to policies that were instituted many years ago that are no longer relevant when delivering services in today's world. In other cases, we must deal with policies that do not reflect the challenges we face in operating a business that serves Medicare beneficiaries.

I will address five such CMS regulations and programs that directly impact small providers in the home health and hospice industry.

I. One Service Provided Directly By Employees

Section 2180D of the State Operations Manual requires that all home health agencies must provide skilled nursing services and at least one of the following other therapeutic services: physical therapy, speech language pathology, or occupational therapy; medical social services, or home health aide services in a place of residence used as a patient's home. The agency must provide at least one of these six services directly and in its entirety by employees of the agency. CMS considers a service to be provided "directly" when the person providing the service for the agency is an agency employee for whom the agency must issue a Form W-2.

This requirement makes it extremely difficult for agencies to respond to sudden changes in patient needs and caseload. The current nationwide shortages of nurses and therapists have made it increasingly difficult for Medicare home health agencies to satisfy the requirement to provide one of their services entirely by their own employees at all times. Agencies must have some flexibility to use contracted staff when necessary to meet unique patient needs and accommodate fluctuations in caseloads. This is particularly true for small home health agencies who serve primarily rural areas like mine, as I do not have the resources to add more employees when my caseload may temporarily increase.

CMS claims that this policy is needed to ensure that agencies are not simply "shell" companies staffed by employees of a staffing company, but the "all or nothing" application of this requirement results in small agencies lacking needed flexibility to adapt to changes in their caseload.

II. Telehealth As A Reimbursable Cost

The use of technology, such as telehealth, that results in more efficient and effective delivery of health care services should be encouraged. However, CMS does not recognize telehealth technology and visit costs as reimbursable under the Medicare home health benefit. Studies indicate that some activities performed by a home health nurse can successfully be done remotely through telehomecare while maintaining or improving quality of care and patient satisfaction. In fact, the Quality Improvement Organizations (QIOs) designated by CMS to assist health care providers to improve their quality of care have urged home care agencies to adopt telehealth interventions for patients with certain diagnoses because they can result in larger yet cost effective improvements in quality of care compared to other types of interventions.

However, small agencies such as mine are unable to invest in such technologies because those costs are not recognized as reimbursable, and there are few resources available to small businesses to make such investments. If CMS moves beyond a pay for performance pilot project for home health services and expands this to all Medicare home health agencies without changing this policy, small agencies like mine will be perpetually disadvantaged by their inability to invest in telehealth technologies to the same degree as larger agencies.

III. Signature Of Home Health Plans Of Care By Physician Assistants And Nurse Practitioners

Nurse practitioners (NPs), clinical nurse specialists (CNS), certified nurse midwives (CNMs) and physicians' assistants (PAs) are playing an increasing role in the delivery of our health care. Many state laws and regulations authorize these non-physician health professionals to complete and sign medical certification documents, and the Balanced Budget Act of 1997 (P.L. 105-35) allowed Medicare to reimburse PAs and NPs for providing physician services to Medicare beneficiaries. In addition, CMS now allows PAs and NPs to sign orders for Medicare hospice services, but not the certification of terminal illness.

However, PAs and NPs and other non-physician health professionals are still prohibited from certifying and signing orders for home health services provided to Medicare beneficiaries. According to CMS, the Medicare statute requires "physician" certification on home health plans of care.

PAs and NPs are increasingly providing medical services to Medicare beneficiaries, especially in rural and underserved areas, and are sometimes more familiar with the particular patient's needs than the attending physician, so allowing PAs and NPs to sign the orders may be more appropriate. In addition, PAs and NPs are sometimes more readily available than physicians to expedite the processing of paperwork, ensuring that home health agencies will be reimbursed in a timely manner and that care to the beneficiary will not be interrupted. Home health agencies cannot submit a final bill for payment without all orders being signed.

For a small agency such as mine located in a rural area, we spend a significant amount of staff and administrative time tracking physicians down to sign orders for treatments and services they ordered for their patients. In some cases, we must literally "camp out" in the physician's office to wait for them to sign their orders. If NPs, PAs, and other non-physician health

professionals could sign the orders, it would reduce our administrative costs and allow us to bill more timely for the services we have provided.

IV. Gas Prices

Rising gas prices have an immediate impact on home health and hospice care, as we are unique among all services provided to Medicare beneficiaries. We travel to the patient because the patient is unable to travel to obtain the care they need. Since patients do not come to us as they do when they seek services at a physician's office, hospital, outpatient clinic, or nursing facility, we incur an additional cost in delivering services that no other provider can claim because we travel to see each and every patient.

Gas prices in Texas have increased more than 25 percent in the past three months and more than 150 percent in the past five years, with no signs of letting up. In 2007, my staff drove 700,000 miles to see home health and hospice patients. The area of Texas that I serve is primarily rural—there is no public transportation that my staff can take to see patients in order to save money. I do my best to ensure that my staff knows which routes will minimize the amount of driving they do. It is not unusual for my nurses to drive more than 100 miles per day. As a small Medicare provider, I don't have the resources to lease a fleet of cars to my staff, as I know some larger agencies have done to cope with this rapidly increasing cost. Rising gas prices have also deterred nurses and therapists from even working for home health agencies and hospices because of the amount of driving involved.

The reimbursement methodologies for home health and hospice services have no way to account for this particular factor that disproportionately impacts their costs compared to other Medicare providers. Home health reimbursement rates are adjusted using a hospital wage index and general inflation indices, which are not accurate or appropriate indicators of home health agency costs. Paying the Internal Revenue Service's mileage rate of $.50 per mile is not an option for most small providers under the current reimbursement methodology. It is imperative that CMS change its rules to reflect the impact of this disproportionate cost on home health and hospice providers through the reimbursement methodology rather than using inappropriate adjustors such as the hospital wage index and general inflation indices.

V. Contingency Plans For Claims Payment Delays

This year marked the first time that CMS had made a substantive change in the home health prospective payment system (PPS) methodology since its inception in 2000. These "refinements" significantly increased the complexity of the methodology in order to more appropriately match payments to patient resource needs. While these refinements were generally supported by the home care industry, there was grave concern that claims payments could be significantly disrupted during the transition. This concern was based on experience from previous years, when "routine" changes in payment amounts that required software and computer programming changes resulted in claims payment delays and/or inappropriate denials of claims that lasted several weeks.

In 2000, CMS created a "contingency plan" during the transition to PPS whereby home health agencies could request advance payments based on their claims payment history if delays in payment occurred. The home care industry requested a similar type of contingency plan be put in place for 2008 during the rulemaking process last year. However, CMS refused to provide for such a contingency plan, stating that they were taking steps *"...internally, to test systems changes before implementation. We do not feel that the vulnerabilities that existed when we moved from a cost-based system to a prospective payment system exist today in moving to a refined HH PPS. Consequently, we do not feel it is necessary to create an elaborate contingency plan as was needed for the implementation of the HHS PPS."* [72 FR 167 p. 49769]

I am here to tell you that now, five and one-half months after the implementation of this refined PPS methodology, CMS is still installing "software fixes", agencies frequently receive only 40 to 50 percent of the episode payment that they are owed, and claims are mysteriously "suspended" for weeks at a time before being released for payment. At the beginning of 2008, it was three weeks into January before any home health agencies saw any claims being paid. Disruptions of this length and magnitude did not occur during the 2000 transition. Many small agencies that I know have had to take out lines of credit with high interest rates (due in large part to the soft economy) just to meet payroll because CMS is still unable to deliver software to their claims payment contractors that will actually pay claims correctly and timely.

CMS claims that this is not a valid concern because agencies are still getting paid (unfortunately not the correct amount) and they are paying claims within the mandated time limit

once they are released. However, this is difficult to absorb for a small business when cash flow is half what it used to be and employees and contractors expect to be paid on time.

These types of "technical problems" disproportionately hurt small agencies. CMS's lack of a contingency plan should not result in providers being unable to maintain their ongoing operations. CMS should be required to have contingency plans in place that are accessible for all Medicare providers when there is a change in the reimbursement system that results in substantive disruptions in claims payments.

The foundation of the Medicare home health and hospice benefits are small companies such as mine, who struggle daily against a mountain of regulations, bureaucracy and paperwork with the simple goal of providing quality services to Medicare beneficiaries. Yet, at times, CMS's policies and regulations sometimes seem to lose sight of that goal and make it difficult for small businesses, like mine, to operate effectively. Thank you again Mr. Chairman and Members of the Committee for the opportunity to testify before you today.